Improving the Quality of Health Care for Mental and Substance-Use Conditions

A Report in the Quality Chasm Series

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The *Crossing the Quality Chasm* Series

To Err is Human (1999)

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Crossing the Quality Chasm

"Quality problems occur typically not because of failure of goodwill, knowledge, effort or resources devoted to health care, but because of fundamental shortcomings in the ways care is organized"

Trying harder will not work: changing systems of care will!

a new HEALTH system for the 21st century (IOM, 2001)

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Six Aims of Quality Health Care

1. **Safe** – avoids injuries from care
2. **Effective** – provides care based on scientific knowledge and avoids services not likely to help
3. **Patient-centered** – respects and responds to patient preferences, needs, and values

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Six Aims (cont.)

4. **Timely** – reduces waits and sometimes harmful delays for those receiving and giving care
5. **Efficient** – avoids waste, including waste of equipment, supplies, ideas and energy
6. **Equitable** – care does not vary in quality due to personal characteristics (gender, ethnicity, geographic location, or socio-economic status)

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Ten Rules for Achieving the Aims

Old Rules	New Rules
1. Care is based on visits.	1. Care is based upon continuous healing relationships.
2. Professional autonomy drives variability.	2. Care is customized to patient needs and values.
3. Professionals control care.	3. The patient is the source of control.
4. Information is a record.	4. Knowledge is shared and information flows freely.
5. Decisions are based upon training and experience.	5. Decision making is evidence-based.

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Ten Rules for Achieving the Aims

Old Rules	New Rule
6. "Do no harm" is an individual clinician responsibility.	6. Safety is a system responsibility.
7. Secrecy is necessary.	7. Transparency is necessary.
8. The system reacts to needs.	8. Needs are anticipated.
9. Cost reduction is sought.	9. Waste is continuously decreased.
10. Preference for professional roles over the system.	10. Cooperation among clinicians is a priority.

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Six Critical Pathways for Achieving Aims and Rules

- News ways of delivering care
- Effective use of information technology (IT)
- Managing the clinical knowledge, skills, and deployment of the workforce
- Effective teams and coordination of care across patient conditions, services and settings
- Improvements in how quality is measured
- Payment methods conducive to good quality

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Study Sponsors

- Annie E. Casey Foundation
- CIGNA Foundation
- National Institute on Alcohol Abuse and Alcoholism
- National Institute on Drug Abuse
- Substance Abuse and Mental Health Services Administration
- Robert Wood Johnson Foundation
- Veterans Health Administration

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Charge to the IOM

Explore the implications of the Quality Chasm report for the field of mental health and addictive disorders;

Identify barriers and facilitators to achieving significant improvements along all six dimensions examining both environmental factors such as payment, benefits coverage and regulatory issues, as well as health care organization and delivery issues.

Based on a review of the evidence, develop an "agenda for change."

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Committee expertise

- M/SU and general healthcare
- Public and private sector M/SU healthcare delivery
- Primary care
- Consumer issues
- Care coordination
- Ethics
- Economics
- Medicaid
- Racial and ethnic disparities in care
- Child M/SU care
- Geriatrics
- Informatics
- Systems engineering

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COMMITTEE ON CROSSING THE QUALITYCHASM: ADAPTION TO MENTAL HEALTH AND ADDICTIVE DISORDERS

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COMMITTEE ON CROSSING THE QUALITY CHASM: ADAPTION TO MENTAL HEALTH AND ADDICTIVE DISORDERS

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CONSTANCE WEISNER - University of California, SF, and Northern California Kaiser Permanente.

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Two Phenomena Central to the Committee's Work and Findings

- Co-occurrence of mental, substance-use, and general health conditions
- The differences in M/SU health services delivery compared to general health care

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Mental and substance-use conditions

Pervasive
- More than 33 million Americans treated annually
  - 20 % of all working age adults (18-54)
  - 21 % of adolescents
- Millions more fail to receive care

Frequently Intertwined
- 15 - 40 % co-occurrence of M and SU illnesses

Often influence general health
- frequently accompany chronic illnesses, e.g., cancer, diabetes, and heart disease
- 20% of heart attack patients suffer from depression, tripling risk of death
- associated with leading causes of outpatient visits, e.g., headache, fatigue and pain

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Mental, substance-use, & general health

CONCLUSION

Improving care delivery and outcomes for any one of the above depends upon improving care and outcomes for the other two.

OVERARCHING RECOMMENDATION

Health care for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body.

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M/SU Health Care Compared to General Health Care

- Increased stigma, discrimination, & coercion
- Patient decision-making ability not as anticipated / supported
- Diagnosis more subjective
- A less developed quality measurement & improvement infrastructure
- More separate care delivery arrangements
- Less involvement in the NHII and use of IT
- More diverse workforce and more solo practice
- Differently structured marketplace

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Improving the Quality of Health Care for Mental and Substance-Use Conditions

Contents

1. The nature of the quality problem in M/SU health care
2. Chasm framework for QI
3. Supporting patient decision making and preferences
4. Strengthening the evidence base and QI infrastructure
5. Coordinating care
6. Ensuring the NHII benefits persons with M/SU needs
7. Increasing workforce capacity
8. Using marketplace incentives for QI
9. A comprehensive agenda for change
10. Constraints on information sharing by federal & state laws, organization practices

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Six Problems in the Quality of M/SU Health Care — and Their Solutions

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Issue 1: Patient-Centered Care

- Patient is the source of control
- Customization of care is based on patient needs and values
- Anticipation of needs
- Shared knowledge and free-flow of information
- Care is transparent to the patient

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Problem 1: Threats to Patient-Centered Care

- Residual stereotypes:
  - impaired decision-making
  - dangerousness
  - drug dependence as solely volitional
- Resulting stigma and discrimination
  - by health care providers
  - in public policy
- Wrongful application of coercion

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Evidence Contradicts Stereotypes

- Great diversity in decision-making capacity (DMC).
- DMC more affected by cognitive ability than psychotic symptoms; DMC can be improved with interventions.
- Inappropriate to make conclusions about DMC based on diagnosis.
- Vast majority of individuals with mental illnesses and no concurrent substance use are at no greater risk of violent behavior than those without M/SU illnesses.
- Contribution of people with mental illnesses to violence is small.
- Drug dependence reflects neurological changes; not simply volitional.
- Patients can have a voice even when care is coerced.

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Stereotypes, stigma and discrimination impair quality by:

1. Lessening patient ability to manage their illness and achieve recovery;
2. Encouraging non-therapeutic clinician attitudes and behaviors; and
3. Fostering discriminatory public policies that create barriers to recovery.

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Lessened patient ability to manage illness and achieve recovery

Stigma pathway to decreased outcomes:

Stigma → ↓ self-esteem → ↓ self efficacy →

↓ ability to manage → ↓ health outcomes / chronic illness recovery

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Non-therapeutic clinician attitudes and behaviors

"We believe that the majority of physicians and other health care providers must fundamentally change their approach toward their patients, an approach revealed through the use of that "special voice." Sadly, far too many professionals have a manner of speaking to us as if we are slightly stupid children.

It's that voice that reminds us that we aren't really partners in care with our health care providers . . .

It's that voice that reminds us that health care providers still think of themselves as taking care of us, instead of working with us.

It's the voice of learned helplessness."

Bergeson, 2004

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Discriminatory public policies create barriers to recovery

- Insurance discrimination
  - Less benefit coverage – especially for children and SU
  - Higher co-pays
  - Loss of child custody solely to secure coverage
- Punishment added to criminal sanctions for non-alcohol substance convictions:
  - Decreased access to student loans
  - Potential lifetime ban on food stamps and welfare

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Six remedies to achieve patient-centered care

1. Combat stigma & support decision making at site of care:
   - Organizational leadership and policies
   - In-service education and orientation
   - Tolerance for "bad" decisions.
2. Involve consumers in design, administration and delivery of care.
3. Provide decision making support to consumers; including peer support and advance directives.

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Six remedies to achieve patient-centered care (cont.)

4. Support illness self-management programs and practices;
5. Make transparent policies for determining decision-making capacity and dangerousness;
6. Preserve patient decision-making in instances of coercion.

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Problem 2: Weak measurement & improvement infrastructure

- **1998** – Mental health care "not well addressed" by existing quality measures and measure sets (President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry).
- **2003** – First National Healthcare Quality Report identifies mental illness as lacking "broadly accepted" and "widely used" quality measures. Of 167 measures of effectiveness of care, only 7 address mental health, 3 on treatment of adult depression, 1 on suicide, and 3 on management of delirium and confusion in nursing homes and home health. None address substance-use. The one measure pertaining to children was for suicide (AHRQ, 2003)
- **2004** – No additional mental health measures included in the second National Healthcare Quality Report; measures of substance-use health care remain absent.

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Weak quality improvement infrastructure

1. Inefficient production of the evidence base
   - Assessment and treatment practices not codified and captured in administrative datasets.
   - Outcome measurement not widely applied.
   - Evidence not mined from observational and other non-RCT study designs
2. Dissemination of advances often fails to use effective strategies and available resources; e.g., CDC;
3. Performance measurement for M/SU health care receives insufficient attention in the private sector; public sector efforts have not yet achieved consensus.
4. QI methods not permeating day-to-day operations of providers of M/SU services.

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Five–part strategy to strengthen the QM/I Infrastructure:

1. Filling gaps in the evidence base via:
   - Alternate study designs
   - Standardizing and coding interventions for capture in administrative data sets
   - Outcome measurement
   - Coordination of initiatives analyzing the evidence;
2. Evidence-based approaches to disseminating evidence;
3. Improving diagnosis and assessment;
4. Building the infrastructure for measuring and reporting quality; and
5. Supporting quality improvement practices at the locus of health care.

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Problem 3:Poor linkages across separations in care

1. Greater separation of M/SU specialty care from general health care;
2. Separation of mental and substance-use health care from each other;
3. Society's reliance on the education, child welfare, and other non-health care sectors to deliver M/SU care; and
4. Location of services needed by individuals with more severe illnesses in public sector programs apart from private sector.
5. Unclear accountability for coordination

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Mechanisms for Coordinating Care

- Routine sharing of patient information between providers with patient knowledge and consent.
- Targeted screening of patients for comorbid mental, substance-use, and general medical problems.
- Evidence-based coordination–linkage mechanisms
- High level policy coordination mechanisms that achieve and model collaboration at the federal and state levels.

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Evidence-based coordination–linkage mechanisms

- Clinical integration of services
- Collocation of services
- Shared patient records
- Case (care) management
- Formal agreements with external providers

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Problem 4: Lack of involvement in the National Health Information Infrastructure

Involvement needed in design of:

- Electronic health records (EHRs)
- Platform for the exchange of info across clinical settings
- Data standards

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M/SU care falling behind in IT

In AHRQ's 2004 awards of $139 million in grants and contracts to promote the use of health information technology, health care for M/SU conditions was not strongly represented in either the applicants or awardees.

Of the nearly 600 applications for funding, only "a handful" had any substantial behavioral health content, and of the 103 grants awarded, only one specifically targeted M/SU health care.

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Actions needed

- DHHS and the Department of Veterans Affairs should charge the Office of the National Coordinator of Health Information Technology and SAMHSA to jointly develop and implement a plan for ensuring that the NHII address M/SU health care as fully as general health care
- Related activities by private sector and purchasers

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Problem 5: Insufficient Workforce Capacity for QI

- Greater variation in M/SU workforce and its education / training
- Across-the-board deficiencies in education; e.g., re: substance use; no "core knowledge" across disciplines
- Variation in licensure /credentialing/continuing education doesn't assure competency
- More solo practice impedes knowledge and technology uptake
- Limited preparation for Internet and other communication technologies for service delivery

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Greater diversity licensed to diagnose and treat

General health care
- Physicians
- Advanced practice nurses
- Physician assistants

M/SU health care
- Psychiatrists
- Psychologists
- Counselors
  - Guidance
  - Addiction
  - Pastoral
  - Other
- Marriage and family therapists
- Social Workers
- Others

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Remedy

- Sustained national attention as has been provided for the physician and nursing workforce.
- Creation of an ongoing, federally funded public–private Council on the Mental and Substance–use Health Care Workforce
- Council to collaborate with institutions of higher education, licensing bodies, accrediting bodies, purchasers, and other private sector initiatives such as AMERSA and the Annapolis Coalition

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Problem 6 of 6: A Differently Structured Marketplace

- Dominance of government (state and local) purchasers,
- Frequent purchase of insurance for M/SU health care separately from other health care (i.e., "carve-out" arrangements),
- Tendency of private insurance to avoid covering or offer more-limited coverage to individuals with M/SU illnesses, and
- Government purchasers' greater use of direct provision and purchase of care rather than insurance arrangements.

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Strategies

- Purchasers offering enrollees a choice of health plans should use one or more tools for reducing adverse selection of individuals with M/SU conditions:
  - risk adjustment,
  - payer "carve-outs,"
  - risk-sharing or mixed-payment contracts, and
  - benefit standardization across the health plans
- Congress and state legislatures should enact coverage parity.
- Reorient State procurement to give greatest weight to quality.
- Use M/SU health care quality measures in procurement and accountability processes.
- State and local governments should reduce emphasis on grant-based systems of financing and increase use of funding mechanisms that link some funds to measures of quality.

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Improving M/SU health care requires action by:

- Clinicians
- Health care organizations
- Health plans
- Purchasers
- State policy officials
- Federal policy officials
- Accrediting bodies
- Institutions of higher education
- Funders of research

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Recommendation 3-1. To promote patient-centered care, all parties involved in health care for mental or substance-use conditions should support the decision-making abilities and preferences for treatment and recovery of persons with M/SU problems and illnesses.

- Clinicians and organizations providing M/SU treatment services should:

– Incorporate informed, patient-centered decision making throughout their practices, including active patient participation in the design and revision of patient treatment and recovery plans, the use of psychiatric advance directives, and (for children) informed family decision making. To ensure informed decision making, information on the availability and effectiveness of M/SU treatment options should be provided.

– Adopt recovery-oriented and illness self-management practices that support patient preferences for treatment (including medications), peer support, and other elements of the wellness recovery plan.

– Maintain effective, formal linkages with community resources to support patient illness self-management and recovery.

(continued on next slide)

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- **Organizations** providing M/SU treatment should also:
  – Have in place policies that implement informed, patient-centered participation and decision making in treatment, illness self-management, and recovery plans.
  – Involve patients and their families in the design, administration, and delivery of treatment and recovery services.
- **Accrediting bodies** should adopt accreditation standards that require the implementation of these practices.
- **Health plans and direct payers** of M/SU treatment services should:
  – For persons with chronic mental illnesses or substance-use dependence, pay for peer support and illness self-management programs that meet evidence-based standards.
  – Provide consumers with comparative information on the quality of care provided by practitioners and organizations, and use this information themselves when making their purchasing decisions.
  – Remove barriers to and restrictions on effective and appropriate treatment that may be created by copayments, service exclusions, benefit limits, and other coverage policies.

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Recommendation 5-2. To facilitate the delivery of coordinated care by primary care, mental health, and substance-use treatment providers, government agencies, purchasers, health plans, and accreditation organizations should implement policies and incentives to continually increase collaboration among these providers to achieve evidence-based screening and care of their patients with general, mental, and/or substance-use health conditions. The following specific measures should be undertaken to carry out this recommendation:

- **Primary care and specialty M/SU health care providers** should transition along a continuum of evidence-based coordination models from (1) formal agreements among mental, substance-use, and primary health care providers; to (2) case management of mental, substance-use, and primary health care; to (3) collocation of mental, substance-use, and primary health care services; and then to (4) delivery of mental, substance-use, and primary health care through clinically integrated practices of primary and M/SU care providers. Organizations should adopt models to which they can most easily transition from their current structure, that best meet the needs of their patient populations, and that ensure accountability.
- Continued...

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- **DHHS** should fund demonstration programs to offer incentives for the transition of multiple primary care and M/SU practices along this continuum of coordination models.
- **Purchasers** should modify policies and practices that preclude paying for evidence-based screening, treatment, and coordination of M/SU care and require (with patients' knowledge and consent) all health care organizations with which they contract to ensure appropriate sharing of clinical information essential for coordination of care with other providers treating their patients.
- **Organizations that accredit mental, substance-use, or primary health care organizations** should use accrediting practices that assess, for all providers, the use of evidence-based approaches to coordinating mental, substance-use, and primary health care.
- **Federal and state governments** should revise laws, regulations, and administrative practices that create inappropriate barriers to the communication of information between providers of health care for mental and substance-use conditions and between those providers and providers of general care.

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Individual Clinicians

Recommendations:

- Support consumer decision-making and treatment preferences;
- Use illness self-management practices;
- Have effective linkages with community resources;
- When coercion unavoidable, make the process transparent;
- Screen for co-morbid conditions;
- Routinely assess treatment outcomes;
- Routinely share clinical information with other providers;
- Practice evidence-based care coordination; and
- Be involved in designing the National Health Information Infrastructure (NHII).

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Organizations Providing Care

Recommendations:

- Have polices to enable and support all actions required of clinicians (on prior slide);
- Involve patients / families in design, administration, and delivery of services;
- If serving a high-risk population (e.g., child welfare, criminal and juvenile justice) screen all entrants for M/SU problems
- Involve leadership and staff in developing the National Health Information Infrastructure (NHII).

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Health Plans and Purchasers

Recommendations:

- For consumers with chronic M/SU illnesses, pay for peer support and illness self-management programs that meet standards;
- Use and provide consumers with comparative info on the quality of M/SU services to select providers;
- Remove payment, service exclusion, benefit limits and other coverage barriers to accessing effective screening, treatment and coordination;
- Support development of a quality measurement and reporting infrastructure;
- (continued)

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Health Plans / Purchasers

Recommendations (cont):

- Require all contracting organizations to appropriately share patient information;
- Provide incentives for the use of electronic health records and other IT;
- Use tools to reduce adverse risk selection of M/SU treatment consumers; and
- Use measures of quality and coordination of care in purchasing / and oversight.

Associations of purchasers work to reduce variation in reporting / billing requirements.

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State Policy-Makers

Recommendations:

- Make coercion policies transparent, use info on comparative quality of providers and evidence-based treatment, and afford consumers choice;
- Revise laws and other policies that obstruct communication between providers;
- Create high level mechanisms to improve collaboration and coordination across agencies;
- Use purchasing practices that incentivize use of EHRs and other IT;
- Enact parity for coverage of M/SU treatment;
- Reorient state procurement processes toward quality; and
- Reorient state purchasing to give more weight to quality and reduce emphasis on grant-based mechanism

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DHHS to charge or create entities to:

- Coordination of identification of evidence–based practices;
- Develop procedure codes for administrative data sets;
- Use evidence–based approaches to disseminate and promote uptake of evidence-based practices;
- Assure use of general health care opinion leaders (e.g., CDC, AHRQ) in dissemination;
- Fulfill essential quality measurement and reporting functions;
- Provide leadership in quality improvement activities; and
- Improve coordination among federal agencies.

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Federal Government also should

- Revise laws, rules, other polices that obstruct sharing of information across providers;
- Fund demonstrations to transition to evidence-based care coordination;
- Ensure that the emerging NHII addresses M/SU health care;
- Authorize and fund an ongoing Council on the Mental and Substance-Use Health Care Workforce similar to the Council on Graduate Medical Education (Congress);
- Support M/SU faculty leaders in health profession schools;
- Provide leadership, development support and funding for R&D on QI in M/SU health care.

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Accreditors of M/SU Health Care Organizations

Recommendations:

Adopt standards requiring:

- Patient-centered decision-making throughout care;
- Involvement of consumers in design, administration, and delivery of services;
- Effective formal linkages with community resources; and
- Use of evidence-based approaches to coordinating mental, substance-use and general health care.

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Institutions of Higher Education

Recommendations:

- Increase interdisciplinary teaching and learning to facilitate core competencies across disciplines; and
- Facilitate the work of the Council on the Mental and Substance-Use Health Care Workforce.

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Funders of Research

Recommendations for research support:

- Development and refinement of screening, diagnostic, and monitoring instruments to assess response to treatment;
- A set of M/SU "vital signs": a brief set of indicators—for patient screening, early identification of problems and illnesses, and repeated use to monitor symptoms and functional status.
- Research approaches that address treatment effectiveness and quality improvement in usual settings of care.
- Research designs in addition to randomized controlled trials, that involve partnerships between researchers and stakeholders, and create a "critical mass" of interdisciplinary research partnerships involving usual settings of care.

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Consequences of the status quo

- M/SU conditions the leading cause of disability /death for American women; the second for American men
- Considerable workplace burden from absenteeism, "presenteeism," disability days, and "critical incidents"
- > 9,000 children placed in juvenile justice system solely to receive MH care

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Overarching Recommendation

Crossing the Quality Chasm's aims, rules, and strategies for redesign should be applied throughout M/SU health care

on a day-to-day operational basis

tailored to reflect the characteristics that distinguish M/SU health care from general health care.

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